

INCIDENT INTAKE INFORMATION

Facility ID #: _____ Date of Intake: _____ Time of Intake: _____
Facility Name: _____ License #: _____
Site Address: _____
City: _____ State: _____ Zip Code: _____ County: _____
Telephone: _____

INCIDENT

Date: _____ Time: _____ a.m./p.m. (drop down) Location: _____

REPORTER

Sal (drop down) First Name: _____ MI: _____ Last Name: _____
Position/Title: _____

CHILD / RESIDENT

First Name: _____ MI: _____ Last Name: _____ Gender: (drop down)
D.O.B.: _____ Age: _____ Address: _____
City: _____ State: _____ Zip: _____ Home # _____

PARENT/GUARDIAN

SAL (drop down) First Name: _____ MI: _____ Last Name: _____
Home # _____ Work # _____ Mobile #: _____
Address: _____ City: _____ State: _____ Zip: _____

WITNESS

Name: _____ Title: _____ Home # _____ Work # _____
Address: _____ City: _____ State: _____ Zip: _____

NAME OF PERSON ALLEGED TO BE RESPONSIBLE FOR INJURY OR MISTREATMENT:

First Name : _____ Last Name _____ Position/Title: _____

Was There An Injury? (Yes/No drop down) If Yes, Describe How Injury Occurred: _____

Describe Activity/Area Where Injury Occurred _____

Staff/Child Ratio At Time Of Incident: _____

Parent/Guardian Notified: (Yes/No drop down) Date Notified: _____ Time Notified: _____ a.m./p.m. (drop down)

Name Of Facility/Physician That Provided Medical Care: _____

Date Medical Attention Was Given: _____ Does Child Still Attend/Reside In Facility: (Yes/No drop down)

SUMMARY OF INCIDENT

Steps Taken By Facility To Prevent Further Incidents: